



Stroke (CVA)/Mini Stroke (TIA)

Please answer all questions applicable to the client's medical history.

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____ Male Female

Face Amount _____ Max Premium \$ _____ /yr. Term Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? Yes No

Frequency _____ Date of last use _____ Type _____

Stroke Mini stroke (TIA) Date _____

What follow-up studies were done following the stroke/mini stroke (select all that apply)

CT scan MRI scan Carotid ultrasound Echocardiogram Other _____

Select the following conditions the client has been diagnosed with

Hypertension; Current reading _____

Elevated cholesterol; Most recent reading _____

Heart attack (MI); Date(s) _____

Diabetes; Date of diagnosis _____ Treatment _____ Most recent A1C result _____

Coronary artery disease; Date of diagnosis; Details _____

Peripheral vascular disease; Date of diagnosis; Details _____

Valve disorders; Date of diagnosis; Details _____

Cardiomyopathy; Date of diagnosis; Details _____

Atrial fibrillation; Date of diagnosis; Details _____

Describe any symptoms experienced at the time of the stroke/mini stroke

Describe any residual neurologic deficits or other residual effects from the stroke/mini stroke

Any changes in ADLs (Activities of Daily Living) Yes No (if yes, describe below) On disability? Yes No

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: